

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**TENNESSEE STATE MEDICAID
FRAUD CONTROL UNIT:
2012 ONSITE REVIEW**



**Stuart Wright
Deputy Inspector General for
Evaluation and Inspections**

**April 2013
OEI-06-12-00370**

EXECUTIVE SUMMARY: TENNESSEE STATE MEDICAID FRAUD CONTROL UNIT: 2012 ONSITE REVIEW OEI-06-12-00370

WHY WE DID THIS STUDY

The Office of Inspector General (OIG) is responsible for overseeing the activities of all Medicaid Fraud Control Units (MFCU or Unit). As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. The reviews describe the Units' caseloads; assess performance in accordance with the 12 MFCU performance standards; identify any opportunities for improvement; and identify any instances of noncompliance with laws, regulations, and policy transmittals.

HOW WE DID THIS STUDY

We based our review on an analysis of data from seven sources: (1) a review of policies, procedures and documentation of the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit director and supervisors; (6) an onsite review of case files; and (7) an onsite review of Unit operations.

WHAT WE FOUND

For Federal fiscal years 2009 through 2011, the Tennessee Unit obtained 96 criminal convictions and 22 civil settlements, and reported recoveries of over \$181 million. We identified one instance of noncompliance with applicable laws, regulations, and policy transmittals: the Unit investigated a case that was not eligible for Federal funding under Federal regulations. With the exception of this instance, our review of compliance issues found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals. We identified two instances in which the Unit did not fully meet Performance Standards. The Unit referred all convicted health care providers to OIG for program exclusion, but did not refer nonprovider convictions. Although the Unit had a training plan, it did not establish training hour requirements for each professional discipline. Additionally, despite Unit efforts to increase referrals, the State Medicaid Agency and managed care organizations sent a small number of fraud referrals to the Unit. Finally, Unit staff and stakeholders reported that involvement on various task forces was key to the Unit's productivity.

WHAT WE RECOMMEND

On the basis of these findings, we recommend that the Tennessee Unit: (1) repay grant funds spent on the case that, under Federal regulations, was not eligible for Federal funding; (2) refer all convictions to OIG, including nonprovider convictions, within 30 days; and (3) establish training hour requirements for professional disciplines. The Unit did not concur with our first recommendation. The Unit stated that it felt the case in question was within its purview. We disagree with the Unit's opinion because the case in question was not one of the three eligible case types specified by Medicaid statute and Federal regulations: investigation of allegations of fraud in the administration of the Medicaid program, in the provision of Medicaid services, or in the activities of Medicaid providers. The Unit should work with OIG to determine ineligible costs.

TABLE OF CONTENTS

Objective	1
Background	1
Methodology	4
Findings.....	7
For FYs 2009 through 2011, the Tennessee Unit obtained 96 criminal convictions and 22 civil settlements, and reported recoveries of \$181 million	7
The Unit investigated one case that, although related to an appropriate case, was not eligible under Federal regulations for Federal funding	8
The Unit referred all convicted health care providers to OIG for program exclusion, but did not refer nonprovider convictions.....	8
Although the Unit had a training plan, it did not establish training-hour requirements for each professional discipline	9
Despite Unit efforts to increase referrals, the State Medicaid agency and MCOs sent a small number of fraud referrals to the Unit.....	9
Unit staff and stakeholders cited involvement on various task forces as key to productivity	11
Conclusion and Recommendations.....	12
Unit Comments and Office of Inspector General Response	13
Appendix.....	14
A: Performance Standards for Medicaid Fraud Control Units	14
B: Unit Comments	18
Acknowledgments.....	20

OBJECTIVE

To conduct an onsite review of the Tennessee State Medicaid Fraud Control Unit (MFCU or Unit).

BACKGROUND

As established by Title XIX of the Social Security Act (SSA) (the Medicaid statute), the mission of State MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.¹ Under the Medicaid statute, each State must maintain a certified Unit unless the Secretary of Health and Human Services (HHS) determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently, 49 States and the District of Columbia (States) have created such Units.³ In Federal fiscal year (FY) 2011, combined Federal and State grant expenditures for the Units totaled \$208.6 million.⁴

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney to carry out its duties and responsibilities in an effective and efficient manner.⁵ Unit staff review complaints provided by the State Medicaid agency and other sources and determine their potential for criminal prosecution. In FY 2011, the 50 Units collectively reported 1,230 convictions, 906 civil settlements or judgments, and recoveries of approximately \$1.7 billion.^{6,7}

¹ Social Security Act (SSA) §§ 1903(q)(3) and 1903(q)(4).

² SSA §§ 1902(a)(61) and 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities.

³ National Association of Medicaid Fraud Control Units (NAMFCU). *NAMFCU Participating States*. Accessed at <http://www.namfcu.net/states> on March 24, 2013. North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.

⁴ Office of Inspector General (OIG) *State Medicaid Fraud Control Units Fiscal Year 2011 Grant Expenditures and Statistics*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2011.asp on March 29, 2013.

⁵ SSA § 1903(q)(6) and 42 CFR § 1007.13.

⁶ OIG, *State Medicaid Fraud Control Units Fiscal Year 2011 Grant Expenditures and Statistics*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2011.asp on April 16, 2012.

⁷ *Ibid.* Recoveries are defined as the amount of money that defendants are required to pay as a result of a settlement, judgment, or pre-filing settlement in criminal and civil cases and may not reflect actual collections. Recoveries may involve cases that include participation by other Federal and State agencies.

The Medicaid statute requires Units to have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with such authority.⁸ If the Unit is in a State that does not have an entity with statewide authority to criminally prosecute individuals, the Unit must have formal procedures approved by OIG to ensure that cases are referred to State entities with criminal prosecutorial authority and that the State entities cooperate with the Unit.⁹ In 44 States, the Units are located within offices of State Attorneys General; in Tennessee and the remaining 5 States, the Units are located in other State agencies.¹⁰

Each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency, and must develop a formal agreement (i.e., Memorandum of Understanding (MOU)) that describes its relationship with that agency.¹¹

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.¹² All Units are currently federally funded on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹³ To receive Federal reimbursement, each Unit must submit an application to OIG.¹⁴ OIG reviews the application and notifies the Unit if it is approved and certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.¹⁵

Under the Medicaid statute, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁶ OIG developed and issued 12 performance standards to define the criteria it applies in assessing whether a Unit is effectively carrying out statutory

⁸ SSA § 1903(q)(1).

⁹ SSA § 1903(q)(1)(B).

¹⁰ NAMFCU. *NAMFCU Participating States*. Accessed at <http://www.namfcu.net/states> on March 29, 2013.

¹¹ SSA § 1903(q)(2); 42 CFR §§ 1007.5 and 1007.9(d).

¹² The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation (FFP).

¹³ SSA § 1903(a)(6)(B).

¹⁴ 42 CFR § 1007.15(a).

¹⁵ 42 CFR § 1007.15(b) and (c).

¹⁶ SSA § 1902(a)(61).

functions and meeting program requirements.¹⁷ Examples of criteria include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all professional disciplines, and establishing policy and procedure manuals to reflect the Unit's operations. See Appendix A for a complete list of the performance standards used for this evaluation.

Tennessee Medicaid Program

TennCare, Tennessee's Medicaid program, provides services primarily through managed care organizations (MCO).^{18, 19, 20} TennCare contracts with and pays MCOs a fixed amount for enrolled beneficiaries. Each MCO contracts with and pays medical providers of services to its beneficiaries. Tennessee contracts with four MCOs: UnitedHealthcare Community Plan, BlueCare, TennCare Select, and Amerigroup.²¹ Total TennCare expenditures in Tennessee for FY 2011 were \$8.4 billion.²²

Tennessee Unit

The Tennessee Unit is housed within the Tennessee Bureau of Investigation (TBI). Neither TBI nor the Tennessee Attorney General has statewide criminal prosecutorial authority; therefore, under the Medicaid

¹⁷ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf> on August 15, 2012. Subsequent to this evaluation, OIG published revised performance standards, effective June 1, 2012. See 77 Fed. Reg. 32645 (June 1, 2012) for the new performance standards. Accessed at <http://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf> on August 15, 2012.

¹⁸ The Centers for Medicare & Medicaid Services (CMS). *Medicaid Managed Care Enrollment Report*. Accessed at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf> on March 29, 2013. MCOs are, generally, health plans that provide and coordinate health care, in return for a predetermined monthly fee, through a defined network of physicians and hospitals.

¹⁹ Ibid. CMS classifies managed care plans as: (1) Medicaid-only MCOs, (2) commercial MCOs, (3) prepaid inpatient health plans, (4) prepaid ambulatory health plans, (5) primary care case management providers, (6) health insuring organizations, (7) programs for all-inclusive care for the elderly, and (8) other organizations that have the structure of the managed care plan but are not described above. For purposes of this report, we use the term MCO to describe all of the above.

²⁰ MCOs in Tennessee do not provide dental and drug benefits. Kaiser Family Foundation, Tennessee, *Comprehensive Medicaid Managed Care Organization Acute Care Benefit Carve-Outs*, October 2010. Accessed at <http://www.statehealthfacts.org/profileind.jsp?ind=987&cat=4&rgn=44> on October 9, 2012.

²¹ TennCare, Managed Care Organizations. Accessed at <http://www.tn.gov/tenncare/pro-mcos.shtml> on December 7, 2012.

²² *MFCU Statistical Data for FY 2011*. Accessed at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on November 14, 2012.

statute, the Tennessee Unit is required to refer cases for prosecution to other State authorities with such authority. The Tennessee Unit also refers cases for Federal prosecution to the three U.S. Attorney's Offices in Tennessee.

The Tennessee Unit expended a total of \$3.7 million in combined Federal and State funds for FY 2011.²³ At the time of our review, the Unit employed 34 staff members including 1 director, 3 supervisors, 2 auditors, 2 attorneys, 2 computer programmers, 1 statistical analyst, 4 support staff, and 19 investigators. The Unit is located in the State capital of Nashville, and has regional offices in Jackson, Memphis, Chattanooga, Knoxville, Columbia, and Johnson City. The Unit has policies and procedures for most operations, and often uses the TBI operations manual. The Unit maintains an electronic system for case management and tracking, known as the Investigative Support Information System (ISIS). Unit investigators prepare case information for Unit administrative staff who enter the information into ISIS. The Unit director and supervisors use ISIS to review case files and run case status reports. Unit case files contain opening and closing supervisory approvals, as well as documentation of supervisory reviews.

METHODOLOGY

Our review covered FYs 2009 through 2011. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation of the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's director and supervisors; (6) an onsite review of case files that were open in FYs 2009 through 2011; and (7) an onsite review of Unit operations. We analyzed data from all seven sources to describe the caseload; assess the performance of the Unit; identify any opportunities for improvement; and identify any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.²⁴ We conducted the onsite review in August 2012.

Data Collection and Analysis

Unit Documentation Review. We reviewed policies, procedures, and documentation of the Unit's operations, staffing, and cases, including its

²³ OIG analysis of Standard Form 425 submitted by Tennessee MFCU for FY 2011.

²⁴ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov>.

annual reports, quarterly statistical reports, and responses to recertification questionnaires.

Review of Financial Documentation. We reviewed Unit financial practices to determine compliance with applicable laws and regulations and to determine the need for additional internal controls. Prior to the onsite review, we reviewed the Unit's financial policies and procedures, its response to an internal control questionnaire, and MFCU grant-related documents such as financial status reports. During the onsite review, we tested a sample of the Unit's purchase and travel transactions. In addition, we reviewed a sample of time and effort records, vehicle records, and the equipment inventory.

Stakeholder Interviews. We conducted structured interviews with key stakeholders who were familiar with the operations of the Unit. Specifically, we interviewed staff from the TennCare Department of Audit and Program Integrity, hereinafter referred to as the State Medicaid agency; the Attorney General's Office, Medicaid Fraud and Integrity Division; the TBI Criminal Investigation Division; Adult Protective Services; the HHS OIG investigators who work with the Unit; the Assistant United States Attorneys; and representatives from all four MCOs. These interviews focused on the Unit's interaction with external agencies.

Unit Staff Survey. We administered an electronic survey to Unit staff. Our questions focused on operations, opportunities for improvement, and effective practices.

Unit Director, Supervisor, and Staff Interviews. We conducted structured interviews with the Unit director, three regional supervisors, two attorneys, and two auditors. We asked respondents to provide any additional information to better illustrate the Unit's operations, identify opportunities for improvement and effective practices, and clarify information we obtained from other data sources.

Case File Review. We selected a statistically valid, simple random sample of 100 case files from the 378 cases open at some point during FYs 2009 through 2011. We reviewed all 100 of these sampled case files for documentation of supervisory approval for the opening and closing of cases, periodic supervisory reviews, timeliness of case development, and the Unit's processes for monitoring the status and outcomes of cases. From these 100 case files, we selected a further random sample of 46 files for a more in-depth review of selected issues, such as the appropriateness and timeliness of investigations.

Unit Operations Review. We reviewed the Unit's operations during our onsite visit. Specifically, we reviewed the process for receiving referrals, electronic case management, security of case files, and general functioning of the Unit.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

For FYs 2009 through 2011, the Tennessee Unit obtained 96 criminal convictions and 22 civil settlements, and reported recoveries of \$181 million

For FYs 2009 through 2011, the Unit filed criminal charges against 111 defendants, obtained 96 criminal convictions, settled 22 civil cases, and was awarded more than \$10 million in criminal recoveries and \$171 million in civil recoveries. Provider fraud represented 63 percent of the Unit's open cases, patient abuse and neglect represented 31 percent, and theft of patient funds represented 6 percent. The Unit's cases represented 30 different provider types; the most common were physicians and home health aides.

The Unit obtained 96 criminal convictions and was awarded more than \$10 million in criminal recoveries

For FYs 2009 through 2011, the Unit filed criminal charges against 111 defendants and obtained 96 criminal convictions. Over half (54 percent) of these convictions were fraud related, 30 percent involved patient abuse and neglect, and 16 percent involved theft of patient funds. Additionally, the Unit was awarded just over \$10 million in criminal recoveries. See Table 1.

Table 1: Unit Criminal Charges, Convictions, and Ordered Restitution, FYs 2009–2011

Criminal Investigations	Charges	Convictions
Fraud	58	52
Patient Abuse and Neglect	38	29
Theft of Patient Funds	15	15
Total	111	96
Criminal Restitution Ordered	\$10,179,675	

Source: OIG analysis of Unit data and quarterly statistical reports, FYs 2009 through 2011, 2012

The Unit obtained 22 civil settlements with more than \$171 million in civil recoveries

The Unit obtained 22 civil settlements as a result of fraud investigations and global cases, resulting in more than \$171 million in civil recoveries.²⁵

²⁵ Global cases are civil false claims cases involving the Federal Department of Justice and other State MFCUs.

Ninety-seven percent (\$167 million) of these settlements were recoveries from global settlements. See Table 2.

Table 2: Unit Civil Recoveries, FYs 2009–2011

	FY 2009	FY 2010	FY 2011	Total Recoveries
Global	\$48,467,120	\$67,626,155	\$50,630,659	\$166,723,934
State Only	\$2,327,933	\$2,342,310	\$0	\$4,670,243
Total	\$50,795,053	\$69,968,465	\$50,630,659	\$171,394,177

Source: OIG analysis of Unit data and quarterly statistical reports, FYs 2009 through 2011, 2012.

The Unit investigated one case that, although related to an appropriate case, was not eligible under Federal regulations for Federal funding

According to the Medicaid statute and Federal regulations, the Unit may receive FFP only for fraud investigations that involve allegations of fraud in the administration of the Medicaid program, in the provision of Medicaid services, or in the activities of Medicaid providers.²⁶ Our review found that the Unit investigated a case that did not involve allegations about these activities and, therefore, costs associated with that investigation are not eligible for FFP. At the time, the Unit director believed that the investigation was within the Unit’s purview because it involved individuals and events related to a prior investigation and therefore Unit agents were best suited to investigate the related matter.

The Unit referred all convicted health care providers to OIG for program exclusion, but did not refer nonprovider convictions

According to Performance Standard 8, the Unit should refer convictions to OIG for purposes of program exclusion within 30 days or another reasonable period after provider sentencing. The Unit referred all convicted health care providers (85 percent of all convictions) to OIG. However, the Unit did not refer to OIG convictions of nonproviders, such as owners of businesses or foster parents. The Unit reported receiving verbal OIG guidance that only convicted health care providers should be referred to OIG, even though OIG requires that all convicted individuals and entities be considered for exclusion.²⁷

²⁶ SSA § 1903(q)(3) and 42 CFR §§ 1007.11(a) and 1007.19(d).

²⁷ In addition to Performance Standard 8, SSA § 1128(a) specifies that individuals and entities convicted of program-related crimes, patient abuse, health care fraud, and felonies relating to controlled substances must be excluded.

Of the convicted health care providers the Unit referred, nearly half (48 percent) were referred within 30 days of sentencing; another 40 percent were referred within 90 days. The Unit referred the remaining 12 percent more than 91 days after sentencing. One convicted health care provider was referred to OIG a full year after sentencing.

Although the Unit had a training plan, it did not establish training-hour requirements for each professional discipline

According to Performance Standard 12, the Unit should maintain an annual training plan for all professional disciplines, including a requirement for a minimum number of hours of training for each. The Unit had a training plan and made funds available to staff for training. However, the training plan did not specify a minimum number of training hours for each professional discipline. All staff reported that the Unit provided them with training opportunities and that the training they received aided the mission of the Unit.²⁸

Despite Unit efforts to increase referrals, the State Medicaid agency and MCOs sent a small number of fraud referrals to the Unit

According to Performance Standard 4, the Unit should have a process to ensure adequate fraud referrals from the State Medicaid agency and other sources. The Unit made efforts to ensure referrals were made, such as updating its MOU with the State Medicaid agency and participating on task forces with the State Medicaid agency and MCOs. However, the State Medicaid agency and MCOs were responsible for a small percentage of the Unit's total fraud referrals —12 percent and 6 percent, respectively. Most referrals of suspected fraud came from other sources, including private citizens (37 percent) and law enforcement entities (14 percent). See Table 3.

²⁸ We recognize that attorneys, investigators, and auditors receive professional and law enforcement training, and that the lack of a requirement for a minimum number of hours of training does not necessarily mean that professional staff are unqualified.

Table 3: Fraud Referrals Received by the Unit, FYs 2009–2011

Source	Number	Percentage
Private Citizens	122	36.5%
Law Enforcement Entities	45	13.5%
State Medicaid Agency	40	12.0%
Other (Includes HHS OIG, Provider Associations, Licensing Boards, Private Health Insurers, MFCU Hotline, and Ombudsman)	38	11.4%
State Agencies	28	8.4%
Prosecutors	24	7.2%
MCOs	19	5.7%
Providers	18	5.4%
Total	334	100.0%

Source: OIG analysis of Unit data collection instrument, 2012.

The Unit made efforts to ensure the State Medicaid agency referred a greater number of fraud referrals

The Unit and the State Medicaid agency reported attempting multiple processes to ensure a greater number of fraud referrals. The first process, effective at the beginning of the review period through June 2010, involved the State Medicaid agency referring all fraud allegations to the Unit. The second process, effective July 2010 through February 2011, involved the State Medicaid agency making determinations regarding the merit of fraud allegations and sending to the Unit only cases that the agency deemed to warrant referral.²⁹ The third and current process, similar to the first, involves the State Medicaid agency referring all fraud allegations to the Unit. However, the current process also involves the State Medicaid agency conducting preliminary analysis on fraud allegations and meeting with the Unit to discuss referrals.³⁰ The Unit and the State Medicaid agency attend monthly task force meetings, during

²⁹ In March 2012, the CMS Medicaid Integrity Group (MIG) reviewed the State Medicaid agency and found that providing only vetted criminal referrals to the Unit was not in alignment with Federal regulation (42 CFR § 455.21), which requires State Medicaid agencies to refer all cases of suspected provider fraud. MIG recommended that the State Medicaid agency develop and implement policies and procedures to refer all suspected provider fraud cases directly to the Unit. CMS, MIG, *Tennessee Comprehensive Program Integrity Review Final Report*, March 2012. Accessed at <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/tmfy11comp.pdf> on August 15, 2012.

³⁰ This process was not in effect during our review period but was in effect at the time of our onsite review.

which the Unit may accept referrals; ask the State Medicaid agency to conduct more analysis; or decide, along with the State Medicaid agency, to close referrals. The Unit and the State Medicaid agency updated their MOU, effective March 2012, to reflect this new referral process.

Unit staff and stakeholders suggested that the small number of fraud referrals from MCOs could be attributed to financial disincentives

Although MCOs oversaw the State's Medicaid providers, they referred only 19 of the Unit's 334 fraud referrals (6 percent). Unit staff and stakeholders reported that although MCOs are contractually required to report confirmed and suspected fraud, they have a financial disincentive to do so.³¹ MCOs are not required to refer billing errors to the State Medicaid agency or the Unit. Stakeholders suggested that MCOs may label confirmed or suspected fraud as billing errors rather than as fraud because MCOs are not allowed to recoup any share of overpayments received from providers at the conclusion of an investigation.

Unit staff and stakeholders cited involvement on various task forces as key to productivity

Unit staff and stakeholders reported that the relationships formed through involvement on task forces, such as the Provider Fraud and Federal Health Care Fraud task forces, were key to the Unit's productivity. The Attorney General's Office formed the Provider Fraud Task Force in 2007 to coordinate stakeholders in combating Medicaid fraud through increased communication and collaboration. The Unit, the State Medicaid agency, and stakeholders such as the Tennessee Department of Human Services' Adult Protective Services unit and other State agencies attended monthly meetings. Additionally, at least one MCO was present at each meeting to discuss suspected fraud cases and all MCOs attended a quarterly meeting. During the task force meetings, stakeholders engaged in discussions about patterns of fraud and abuse, referrals, and case examples, and occasionally offered training. The Unit also participated in three Federal Health Care Fraud task forces in various parts of the State. According to the Unit director, most of the Unit's fraud cases are prosecuted federally, making participation on these Federal task forces essential.

³¹ Section 2.20.2 of TennCare MCO contracts requires MCOs to report all confirmed or suspected fraud and abuse to TennCare, TennCare Office of Program Integrity, TBI MFCU, and/or OIG.

CONCLUSION AND RECOMMENDATIONS

For FYs 2009 through 2011, the Tennessee Unit obtained 96 criminal convictions and 22 civil settlements and reported recoveries of \$181 million. Unit staff and stakeholders reported that involvement on various task forces was key to the Unit's productivity.

We identified one instance of noncompliance with applicable laws, regulations, and policy transmittals. The Unit investigated a case that, although related to an appropriate case, was not eligible under Federal regulations for Federal funding. With the exception of this instance, our review of compliance issues found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals. Additionally, we identified two instances in which the Unit did not fully meet Performance Standards. The Unit referred all convicted health care providers to OIG for program exclusion, but did not refer nonprovider convictions. Finally, although the Unit had a training plan, it did not establish training-hour requirements for each professional discipline.

To address the noncompliance issues and the opportunities for improvement identified by our review, we recommend that the Tennessee Unit:

Repay Grant Funds Spent on the Case That Was Not Eligible Under Federal Regulations

The Unit should work with OIG to identify the staff hours and expenditures associated with the ineligible case and repay the Federal grant funds.

Refer All Convictions to OIG, Including Nonprovider Convictions, in a Timely Manner

The Unit should refer all convictions, including nonprovider convictions, to OIG for purposes of program exclusion. The Unit should improve its processes for referring convictions to OIG and refer convictions within 30 days from the date of sentencing.

Establish Training-Hour Requirements for Professional Disciplines

The Unit should revise its training plan to include a minimum number of training hours for each professional discipline.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with all but the first of our three recommendations.

Regarding our second recommendation, the Unit stated that it now refers nonprovider convictions in a timely manner to OIG for purposes of program exclusion. The Unit stated that it had been operating under instruction from OIG that it was not necessary to refer nonprovider convictions to OIG. The Unit's concurrence is consistent with performance standard 8, which states that a MFCU should provide "reports of convictions" to OIG within 30 days or other reasonable time period, and does not limit such convictions to those involving health care providers. OIG's exclusion authority, contained in section 1128 of the SSA, is similarly not limited to health care providers. Nonproviders, especially for patient abuse cases, may be subject to conviction and should be referred to OIG for potential program exclusion.

Regarding our third recommendation, the Unit stated that it modified its training plan to include a minimum number of training hours for each professional discipline.

The Unit did not concur with our first recommendation to repay grant funds spent investigating the case that, under Federal regulations, was not eligible for Federal funding. The Unit stated that it felt that the case in question was an extension of an existing investigation, that the case was within its purview, and that the Unit was justified in conducting the investigation. While we agree that the case was an extension of an authorized investigation, OIG has no authority to reimburse a Unit for the investigation of cases that do not involve either health care fraud or patient abuse or neglect. The Unit should work with OIG to determine the amount of ineligible costs relating to the time spent on the case.

The full text of the Unit's comments is provided in Appendix B. We did not make any changes to the report based on the Unit's comments.

APPENDIX A

Performance Standards for Medicaid Fraud Control Units

[59 Fed. Reg. 49080, Sept. 26, 1994]

1. **A Unit will be in conformance with all applicable statutes, regulations and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:
 - a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.
 - b. The Unit must be separate and distinct from the single State Medicaid agency.
 - c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.
 - d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.
 - e. The Unit must submit quarterly reports on a timely basis.
 - f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.
2. **A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:
 - a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by the OIG?
 - b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?
 - c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?
 - d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?
3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:
 - a. Does the Unit have policy and procedure manuals?

- b. Is an adequate, computerized case management and tracking system in place?
- 4. A Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit work with the single State Medicaid agency to ensure adequate fraud referrals?
 - b. Does the Unit work with other agencies to encourage fraud referrals?
 - c. Does the Unit generate any of its own fraud cases?
 - d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?
- 5. A Unit's case mix, when possible, should cover all significant provider types.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit seek to have a mix of cases among all types of providers in the State?
 - b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?
 - c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?
 - d. Are there any special Unit initiatives targeting specific provider types that affect case mix?
 - e. Does the Unit consider civil and administrative remedies when appropriate?
- 6. A Unit should have a continuous case flow, and cases should be completed in a reasonable time.** In meeting this standard, the following performance indicators will be considered:
- a. Is each stage of an investigation and prosecution completed in an appropriate time frame?
 - b. Are supervisors approving the opening and closing of investigations?
 - c. Are supervisory reviews conducted periodically and noted in the case file?

7. A Unit should have a process for monitoring the outcome of cases.

In meeting this standard, the following performance indicators will be considered:

- a. The number, age, and type of cases in inventory.
- b. The number of referrals to other agencies for prosecution.
- c. The number of arrests and indictments.
- d. The number of convictions.
- e. The amount of overpayments identified.
- f. The amount of fines and restitution ordered.
- g. The amount of civil recoveries.
- h. The numbers of administrative sanctions imposed.

8. A Unit will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?
- b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?
- c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?
- d. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

9. A Unit should make statutory or programmatic recommendations, when necessary, to the State government. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?

- b. Does the Unit provide program recommendations to single State agency when appropriate?
 - c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?
- 10. A Unit should periodically review its memorandum of understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice.** In meeting this standard, the following performance indicators will be considered:
- a. Is the MOU more than 5 years old?
 - b. Does the MOU meet Federal legal requirements?
 - c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?
 - d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?
- 11. The Unit director should exercise proper fiscal control over the Unit resources.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?
 - b. Does the Unit maintain an equipment inventory?
 - c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?
- 12. A Unit should maintain an annual training plan for all professional disciplines.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit have a training plan in place and funds available to fully implement the plan?
 - b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?
 - c. Are continuing education standards met for professional staff?
 - d. Does the training undertaken by staff aid to the mission of the Unit?

APPENDIX B Unit Comments



BILL HASLAM
GOVERNOR

TENNESSEE BUREAU OF INVESTIGATION

901 R.S. Gass Boulevard
Nashville, Tennessee 37216-2639
(615) 744-4000
Facsimile (615) 744-4500
TDD (615) 744-4001



MARK GWYN
DIRECTOR

March 14, 2013

Mr. Stuart Wright
Deputy Inspector General for Evaluation and Inspections
Room 5660, Cohen Building
330 Independence Avenue, SW
Washington, D.C. 20201

RE: Tennessee State Medicaid Fraud Control Unit: 2012 Onsite Review, OEI-06-12-00370

Dear Mr. Wright,

In response to your letter dated February 19, 2013, which contained the draft report of the TN MFCU 2012 Onsite Review, I would like to begin by thanking your staff members for the professionalism they demonstrated during the review process. The review team represented your department well during their on-site visit and conducted themselves with the utmost integrity. They were careful not to disrupt ongoing activities of the unit while accumulating and reviewing the necessary information for the audit.

I will address the recommendations in the report in the order they are listed.

The Unit investigated one case that, although related to an appropriate case, was not allowed under Federal regulations.

We do not concur with this recommendation. We expressed our reasons during the exit conference, and our position has not changed. We feel the case in question was within our purview, and we were justified in conducting the investigation; it was an extension of an existing Medicaid Fraud investigation.

The Unit referred all convicted health care providers to OIG for program exclusion, but did not refer non-provider convictions.

Page 1 of 2



INTERNATIONALLY ACCREDITED SINCE 1994

We concur with this recommendation, but would like to include we had been operating under instruction from HHS-OIG that it was not necessary to report non-provider convictions. In accordance with your recommendation, we are now including non-provider convictions to OIG for purposes of program exclusion, in a timely manner.

Although the Unit had a training plan, it did not establish training-hour requirements for each professional discipline.

We concur with this recommendation and have already modified our training plan to include a minimum number of training hours for each professional discipline.

I appreciate the opportunity to respond to this report, and I am available to answer any questions you may have. Please feel free to contact me or Special Agent in Charge Norman Tidwell at 615-744-4322 if you need additional information.

Sincerely

/S/

Mark Gwyn
Director

MRG/nt

xc: Deputy Director Jeff Puckett
SAC Norman Tidwell

ACKNOWLEDGMENTS

This report was prepared under the direction of Kevin Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office; Blaine Collins, Deputy Regional Inspector General; and Ruth Ann Dorrill, Deputy Regional Inspector General.

Lyndsay Patty served as the Team Leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Ben Gaddis. Office of Investigations staff who provided support include Ryan Houston and Jason Weinstock. Central office staff who provided support include Susan Burbach, Kevin Farber, Debra Roush, and Richard Stern.

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.